Maternal-Infant Health Program Design Workgroup Notes

November 18, 2004

Present: Dianna Baker, Mark Bertler, Lynette Biery, Sandy Brandt, Alethia Carr, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Sheila Embry, Brenda Fink, Judy Fitzgerald, Pat Fralick, Sue Gough, Mary Ludtke, Deb Marciniak, Doug Paterson, Jackie Prokop, Cami Purifoy (for Sharon Wallace), Diane Revitte, Carolynn Rowland, Paul Shaheen, Tom Summerfelt (presenter), Betty Tableman, Sharon Wallace, Peggy Vander Meulen.

Present via phone: Anne Bianchi, Rosemary Blashill, Leslie Boulette (for Rick Haverkate) Nancy Heyns, Dana Samples (for Geri Toney).

Not present: Bonnie Ayers, Dianne Douglas, Sheri Falvay, Adnan Hammad, Rick Haverkate, Nancy Heyns, Ed Kemp, Sue Moran, Rick Murdock, Mary Pat Randall, Betty Yancey.

Future MIHP Design Workgroup Meeting Dates - NOTE DATE, TIME AND LOCATION CHANGES

~~Thursday, Dec. 16, 2004~~	~~1:00 pm to 3:30 pm~~	CANCELLED
Friday, Jan. 21, 2005	10:00 am to 12:30 pm	MPHI Interactive Learning Center
Thurs., Feb. 17, 2005	1:00 pm to 3:30 pm	MPHI Interactive Learning Center
Thurs., Mar. 17, 2005	1:00 pm to 3:30 pm	MPHI Interactive Learning Center

Tasks / Assignments

1. Deb will ask Raquel Montalvo to add Phyllis Meadows, Detroit Deputy Health Officer, to the DWG roster.
2. Deb will start to keep a running list of systems issues.
3. DWG members will carefully review the *MIHP Goals, Objectives, and Outcomes Conceptual Matrix* and send their input to Lynette by Dec. 3 at lynette.biery@ht.msu.edu.
4. Lynette and Tom will revise the *Matrix* based on the input they receive for discussion at our Jan. 21 meeting.
5. Deb will make the changes (in bold) that were suggested today regarding the *Maternal-Infant Health Program Design Criteria* and distribute it to DWG members to share with their constituents.
6. The MIHP Steering Committee will pull together a program design subcommittee to work on the key risks that we intend to address and put flesh on the bones of the program design.
7. The MIHP Steering Committee will propose the charge for a finance subcommittee and identify potential members.

Welcome, Introductions, Questions

Brenda reviewed the meeting goals as identified on the agenda and participants introduced themselves. She asked if there were questions on the handout packet.

Q. Will the new program design be based on the statewide data presented at our Oct. 6 meeting? The aggregated state data includes large population counties with low penetration rates, which skews the results. It doesn't indicate which programs are doing better on certain indicators, so we are unable to learn best practices from them.
A. The data presented at our first meeting were intended to provide "the big picture." ICHS also has county-level data, including data on programs that have good penetration rates and outcomes, which they will provide when we address interventions. We definitely want to translate what we learn from national and state models / best practices into our program design.

Q. Do infant mortality rates vary significantly from county to county?
A. Yes, and we will look at this data.

The Population Management Model

To preface the discussion on the population management model, Lynette reminded us that the key findings of the data presented in October were:

- MSS/ISS is not reaching the highest risk women.
- MSS/ISS activities are not linked to purported outcomes.
- Birth outcomes of enrolled women are not different than those of non-enrolled women.

23% of eligible women are enrolled in MSS; 16.5% of eligible infants are enrolled in ISS; and 9.2 % of enrollees get both MSS and ISS. The number of risk factors a woman has is not related to whether or not she is enrolled in MSS. 80-90% of eligible women enroll in WIC because they receive coupons. MSS needs incentives – linking with WIC would help. The woman's readiness to change needs to be taken into consideration.

Stacey Duncan-Jackson did a PowerPoint presentation titled, *Disease Management: Using a Systematic Approach to Improve Care*. Stacey has a quality improvement background. She was the Disease Management Director at the Blues for a number of years and did a high-risk pregnancy project there. She noted that the terms "disease management and "population management" are synonymous, but that "population management" is more applicable to pregnancy, as it is not a disease.

Disease management (DM) is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. DM is a specific application of the QI process that is population-based, systematic, and data-driven. DM program components include: data analysis and planning; evidence-based guidelines; population identification; registries; population stratification; interventions; outcome measurement and reporting. DM is not going away.

Some key features are the following:

- Must decide if we will have an opt-in or opt-out program design. An opt-in program will skim off the top.

- Evidence-based guidelines define care expectations based on evidence. They include clinical practice guidelines, clinical paths, algorithms, and pharmacy guidelines.
- Population identification is systematic and criteria based; a wide net is cast to draw the population in (multiple referral sources).
- Registries allow for tracking of individual patients over time. Registry = database. Registry lists all eligible and enrolled patients, tracks patient status (stratification, recommended services, interventions, and outcomes). May be very simple or very complex. Links outcomes/profiling/incentives.
- Stratification systematically divides the population into segments (e.g., high, moderate and low risk) according to severity, predictive modeling, health status, comorbidities/complexities in order to prioritize scarce resources. Generally, 20% of the population gets 80% of the resources. Women may move across categories over time.
- Predictive models are mathematical models that help with stratification and resource allocation. Dependent on integrity of data. We don't have one for pregnancy at this time, but we can't wait until we do – we must start somewhere.
- Interventions are based on what works in similar settings/populations. Research with RCTs is desirable, but not always available. Interventions vary according to stratification level and are culturally appropriate. Interventions are identified through benchmarking (industry best-practice), lit searches, and networking.
- Measuring outcomes is necessary to determine if our interventions make a difference. Requires that agencies share data. We have to get away from clinical record review as data collection method.
- Data analysis drives program decisions. Constantly combing the data to see if interventions are working. Can't do all things for all people.

Judy noted that Saginaw has tablets for collecting info for a central database. We could ask them to talk with us about this.

It was suggested that it would be useful to have client focus groups around the state to ask them what works. Lynette noted that ICHS has done interviews with Kent Co. clients.

Brenda asked if it was acceptable to move forward with the population management approach, and the DWG said yes.

MIHP Goals, Objectives, and Outcomes Conceptual Matrix

Lynette presented the *MIHP Goals, Objectives, and Outcomes Conceptual Matrix*. It is the next iteration of the document handed out in October titled, *MSS Draft Program Goal, Objectives, and Associated Outcome Measures*. In an effort to be as clear as possible, this version does not include outcome measures – it simply identifies our desired program outcomes. It also distinguishes between proximal, intermediate and distal outcomes, which are conceptualized as a developmental process. As we succeed at achieving these outcomes, we might create benchmarks. Once we agree upon the outcomes, we can determine the outcome measures, although there will be some

outcomes we may not be able to measure. We can develop program process measures and discuss individual client outcomes after we complete the program outcome measures.

Lynette noted that we need to be careful not to choose outcomes that no one knows how to achieve at this time (e.g., increasing birth weight or gestational age), or we are setting our program up for failure. Tom said we want to be sure that we spend our funds on interventions that clearly can benefit the population, and we have to monitor population data over the long-term (10-15 years). The programs that get the best results are targeted – they allow some variation, but they focus on risks that are amenable to intervention so they can achieve their desired outcomes. Interventions may be more effective with some subpopulations than others, or than with the population as a whole.

Lynette stressed that the matrix should have DRAFT written all over it, as it is not definitive at this point. Today she is asking the group to indicate whether or not we are headed in the right direction with this document. Are there major omissions? Can we leave this meeting with agreement to go forward with it?

Pat noted that the matrix doesn't address systems issues that have a major impact on our efforts to achieve our desired outcomes, such as the reality that physicians aren't willing to see women until they are in their second trimester. Should we include "pie-in-the-sky" outcomes in the matrix? Yes – or they will never get addressed. We need to aim high and remember that there are other people besides us who are responsible for improving infant mortality and morbidity. Sue noted that a health plan blamed an MSS provider because the plan's postpartum check-up rates were so low, which illustrates the need for buy-in from, and collaboration with, lots of players. Tom said we need to embed the sense that we will attack issues systemically, but we need to prioritize where we'll have the most impact. Lynette said we can't hold people accountable for outcomes over which they have no control. We need to be sure the design is vetted so it works. Deb will start to keep a running list of systems issues.

Some suggestions regarding the matrix included the following:

1. Add basic needs. (This was left off inadvertently and is included in the screening tool that's under development. Lynette will include basic needs in the next draft.)
2. Develop the infant side more clearly.
3. Add safe sleep - keeping kids alive in the first year is important. (It would be difficult to measure safe sleep behavior – all parents will say they do what's recommended.)
4. What about the "other proposed indicators" at end of matrix? (Lynette suggests we drop them.)

Brenda asked if we support the approach reflected in document, realizing it needs additional work, and that we must wrestle with ensuring that we actually can achieve our identified outcomes through the program we design, as they relate to our broad, long-term goals. Stacey noted that the core objectives can be consistent with broader goals – we address what the program can do with the indicators we select. In other words, we will address what the program is accountable for when we select our indicators. The

matrix just identifies what outcomes we want to see for women in the program. Then we must design a targeted program that will get us to those outcomes. The DWG affirmed the approach and asked Lynette and Tom to take it to the next iteration. DWG members will carefully review the matrix and send their input to Lynette by Dec. 3 at lynette.biery@ht.msu.edu. We need to think of the matrix as a constant work in progress. We'll revisit it at our next meeting.

Maternal-Infant Health Program Design Criteria

The DWG reviewed and commented on *Maternal-Infant Health Program Design Criteria* (handout 8). Doug said that Dr. Olds says the hardest thing to do is to keep women engaged, which is why he insists on having nurses as home visitors – they are non-threatening and are so well accepted by women. Lynette noted that Olds admits that some sub-populations do better with parapros. Pat said that her staff are taught to be salespersons. Sue said that most women think everyone on the MSS team is a nurse. Doug would like to add "engage high-risk women" as a bullet in our immediate program goal. Deb will make the suggested changes in bold and send the revised version out to DWG members, so they may share it with their constituents.

Next Steps

Doug said that we're planning to have the design completed for the next fiscal year, which means that we really need to have it by spring, so we're on a very fast track. We need a smaller group to determine/affirm the risk factors we will address and to begin to put flesh on the bones of the program design.

We decided to cancel the DWG meeting scheduled for Dec. 16 in order to have time to pull a subcommittee together and develop documents for the DWG to review at our Jan. 21 meeting. We can also use email for review and comment, which has worked well for the Early Childhood Comprehensive System strategic planning initiative. Our MIHP web site is under construction and should be up soon.

We also need to start thinking about reimbursement mechanisms that promote accountability. We have talked about moving from FFS to capitation. Ingrid said that providers would resist this. Pat asked how moving toward capitation would change performance in the big population counties that don't perform well now on FFS. Ultimately, we will need CMS approval to make any changes we propose.

Agenda for Jan. 21 05 DWG Meeting

1. Make final determination on the key risks that we intend to address.
2. Review the work of the program design subcommittee.
3. Develop charge for the finance subcommittee and identify potential members.

Parting Note

Brenda thanked the DWG members for their participation. She asked that when members share DWG materials with their constituents, they not circulate meeting notices, as this leads some people to infer that they should attend the meeting.

Running List of Systems Issues

1. Physicians won't see women until they're in their second trimester.
2. HEDIS says that a postpartum visit must occur on or between 21 days and 56 days after delivery, but many women go earlier, so the visit doesn't count.
3. Service capacity is limited (e.g., substance abuse treatment). (Do we have effective treatment models? How available are they? If the service were reimbursable under the MIHP, would it create more capacity?)
4. May women refuse the program because they fear the system will remove their children.
5. Loss of Medicaid outreach funds. Availability of resources is a constant tension.
6. An MSS program had a CMH employee as the social worker on its team. CMH wouldn't allow her to serve MSS clients because the MSS MA rate was less than the CMH MA rate.
7. *The Paternity Act. MCLA, 722.712. Child born out of wedlock; liability of parents for expenses*. Section 2 (2). If Medicaid has paid the confinement and pregnancy expenses of a mother…based on the father's ability to pay and any other relevant factors, the court may apportion not more than 100% of the reasonable and necessary confinement and pregnancy costs to the father…(4) The court order shall provide that if the father marries the mother after the birth of the child and provides documentation of the marriage to the friend of the court, the father's obligation for payment of any remaining unpaid confinement expenses is abated subject to reinstatement after notice and hearing for good cause shown, including, but not limited to, dissolution of the marriage.